

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445128	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/13/2014
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NAME OF PROVIDER OR SUPPLIER

NHC HEALTHCARE, OAK RIDGE

STREET ADDRESS, CITY, STATE, ZIP CODE

300 LABORATORY RD  
OAK RIDGE, TN 37831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have self-closing doors in hazardous areas. The findings include: Observation on November 13, 2014 at 11:40 a.m. and 2:10 p.m. revealed the following hazardous areas are over 50 square feet and storing combustibles, did not have doors that are self-closing: 1. Dietary has 2 dry storage rooms that are not provided with doors that are self-closing. 2. The down stairs medical record storage room is not provided with a door that is self-closing. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on November 13, 2014.</p>	K 029	<p>This plan of correction is submitted as required under State and Federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p>1. Door closures have been installed on the 2 dry storage rooms in dietary and the downstairs medical record storage room as of 12-1-14.</p> <p>2. No other areas were affected.</p> <p>3. There are no other areas identified that would require door closures.</p> <p>4. Maintenance will periodically monitor to ensure fixtures are properly functioning.</p>	12/5/14
K 038 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, OAK RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 300 LABORATORY RD OAK RIDGE, TN 37831		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	Continued From page 1  This STANDARD is not met as evidenced by: Based on observation and testing, it was determined that the facility failed to have doors in the means of egress readily accessible at all times. The findings include: 1. Observation and testing on November 13, 2014 at 12:00 p.m. revealed 8 of 8 delayed egress doors do not have the required lettering for the delayed egress signage on a contrasting background. The delayed egress signage is on a clear adhesive background with red lettering and on a glass door which makes the signage not clearly visible. 2. Observation and testing on November 13, 2014 at 2:25 p.m. revealed the delayed egress door in the activity room did not release when the fire alarm was activated. This door is 1 of 8 of all of the delayed egress doors. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on November 13, 2014. NFPA 101 7.2.1.6.1, NFPA 72 3-9.7.2	K 038	1. The 8 of 8 delayed egress signs have been replaced, on 12/3/14, with contrasting background. The delayed egress door in the activity room was corrected on 11/20/14.  2. No other areas were affected.  3. There are no other doors that will need to be repaired.  4. Maintenance will monitor to ensure delayed egress doors are properly functioning.	12/5/14	